| | | | |
|---|---|---|---|
| Methodist Health Services Corporation & UnityPoint Health Methodist\|Proctor<br><br>Laboratory<br><br>ADMINISTRATION | Page 1 of 3 | Section: UPPIA LA: Personnel/HR | Policy : 01.007<br>Formerly: A-7 |
| | Approved by: see signature block at end of document | | Date: 10/25/16 |
| | Revised: 10/25/16, 7/7/16, 1/26/16, 11/2/10, 1/31/10, 5/7/08, 1/7/03, 6/13/02, 6/16/00, 8/9/98, 12/30/97, 5/10/06, 11/7/11 | | |
| | Reviewed: 3/10/14 | | |
| | Policy/Revision Submitted by: Rich Borge | | |
| | CAP Standard: 55500, 5525, 57000 | | |
| POLICY GUIDELINE ON: **Competency Assessment of Personnel** | | | |

## I. POLICY:

All laboratory personnel will be evaluated for competency to meet CLIA standard.

## II. PURPOSE:

1. To meet the CLIA regulation that all personnel performing high and moderate complexity testing to be evaluated on routine basis for competency.
2. To establish criteria and methods for determining competency of procurement and testing personnel.
3. The terms testing personnel and tech will be used synonymously throughout this policy and are meant to include clinical laboratory scientist, clinical laboratory technician, clinical laboratory assistant, and phlebotomists.
4. To meet the regulations that section Medical Directors are deemed competent.

## III. SCOPE:

This policy applies to all laboratory staff at both campuses and the contracted pathology group.

## IV. GENERAL INFORMATION:

1. It is the responsibility of the manager and respective coordinator(s) to assure that the staff is competent in collection of specimens and processing of specimens and/or accurately performing and resulting tests.
2. Competency assessment of personnel maybe based upon, but is not limited, to the following:
   a. Direct observation of collection, patient identification and preparation and/or processing of specimens.
   b. Direct observation of test performance including specimen handling, testing, reporting, instrument maintenance, and function checks.
   c. Review of proficiency testing reports.
   d. Review of quality control records, worksheets, and preventive maintenance records.
   e. Review of problem logs, work center activity report, result review report, worksheets & other manual computations.
   f. Assessment of test performance through previously analyzed specimens, internal blind testing samples or external proficiency testing
   g. Evaluation of problem solving skills.
   h. Written exams.
   i. The MTS Competency Assessment Program is used to challenge testing personnel at least annually

j. Review of Event Reporting System, RL Solutions for trends

3. Evaluation and documentation of the competency of individuals responsible for laboratory testing is performed after initial training and at least semi-annually during the first year the individual tests patient specimens. Thereafter, competency must be evaluated at least annually unless test methodology or instrumentation changes, in which case, prior to reporting patient test results, the individual's performance must be re-evaluated to include the use of the new test methodology or instrument.
4. When test methodology or instrumentation changes, the individuals' competency must be re-evaluated to include the use of the new instrumentation prior to collecting and administering blood.
5. Employee will be deemed competent if he/she:
   a. Consistently collects quality specimens without complaints from patients.
   b. Consistently performs testing according to SOPs including patient preparation, specimen handling, processing, testing, and reporting as observed by peers, coordinator, and/or managers.
   c. Successfully performs proficiency testing.
   d. Capable of performing, evaluating, and recording quality control. Demonstrates and understanding of quality control and its importance to the testing process. Recognizes a system that is not in control and is able to initiate steps to bring system back into control. Fully documents all actions.
   e. Resolves problems and satisfactorily completes problem logs including appropriate documentation of facts and follow-up as observed by peers, coordinator, or managers.
   f. Completes quizzes and/or exams with a score of 80% or better.
6. An employee will be deemed not competent if:
   a. Consistently receives complaints from patients.
   b. Through observations is not following collection and processing policies or procedures.
   c. Receives less than satisfactory performance on competency tests.
   d. Does not perform, evaluate, and record quality control according to established policy.
   e. Consistently commits errors or omissions in documentation.
   f. Scores less than 80% on quiz or exam.

   For those employees deemed not competent, he/she will not be allowed to perform their duties until he/she is re-educated and a competency checklist has been completed. Assessment will be re-evaluated before further collection of component.
7. A pathologist designated as the section Medical Director (Technical Supervisor) will be deemed competent if he/she meets the bi-annual evaluations of the Department Medical Director. Those Competency sheets reside with the policy (form # 01.007.01) and completed forms are located with the policy manual of the respective section.

## V. PROCEDURE:

1. Testing personnel performing high or moderate complexity testing will have their competency assessed by the lead tech of each laboratory section and/or by another tech meeting the educational, training and experience requirements recommended by the CAP.
2. Elements of competency are assessed by routine review throughout the year.

3. In assessment of competency, the resource coordinator/manager will review employee's file for competency checklists, documentation of proficiency testing results, documentation of coaching and counseling sessions pertaining to performance and quiz/exam scores.
4. Manager will compile performance feedback from peers/leads/coordinator, physicians, etc.
3. Competency will be documented on employee's Education & Competency Summary form, submitted with their MTS competency transcript, and reviewed with employee annually.

## VI. MAINTENANCE:

A. All policies and procedures are reviewed annually by Laboratory Administration and or the Medical Director of the Laboratory or designee
B. The Laboratory Administration and Medical Director review policies and procedures when there are changes in practice standards, or requirements.
C. All policies and procedures are reviewed annually by staff or at the time new or revised ones are put in effect.
D. All policies are retained 8 years after being discontinued or revised.
E. All procedures are retained 2 years after being discontinued or revised.

| **REVISION HISTORY (began tracking 2012)** | | | |
|---|---|---|---|
| **Rev** | **Description of Change** | **Author** | **Effective Date** |
| 1 | System logo updated, formatting changes. Added use of event reporting system for comp review. Changed MTS to annual frequency. Removed use of Educational Growth and Development Record. | Theresa King | 3/10/14 |
| 2 | Addition of who will perform competency assessment | R. Fitzgerald | 7/7/16 |
| 3 | Added pathology group nee competency assessments and an evaluation will be done bi-annually | R. Borge | 10/23/16 |

**Reviewed by**

| **Designee** | **Date** | Laboratory Director | **Date** |
|---|---|---|---|
| | | Richard J. Borge | 1/26/16 |
| | | Richard J. Borge | 7/8/16 |
| | | Richard J. Borge | 10/25/16 |
| | | | |
| | | | |
| | | | |